STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065307	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mantey Heights Rehabilitation & Care Center	2825 Patterson Rd Grand Junction, CO 81506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to timely report an allegation of abuse involving three (#2, #1 and #5) of five residents reviewed for abuse out of five sample residents.Specifically, the facility failed to throughly investigate and timely report two allegations of sexual abuse by Resident #1 toward Resident #2 and Resident #5. Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised September 2022, was provided by the nursing home administrator (NHA) on 2/17/26 at 5:59 p.m. It read in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If abuse, neglect, exploitation, or misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and two other officials according to state law. The administrator or other individuals making the allegation immediately reports his or her suspicion to the following person or agencies: The state licensing/certification agencies responsible for surveying/licensings of facility; the local/state ombudsman; the residents' representative; aAdult Protective services; law enforcement officials; and, facility medical director. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents.According to the policy, the facility should report within two hours of the allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.II. Incident between Resident #1 and Resident #2A. Facility investigation A 10/13/25 sexual abuse investigation was provided by the NHA on 2/17/26 at 4:05 p.m. The investigation provided was an incident reported submitted to the State Agency on 10/16/25. According to the incident report, the incident that prompted the allegation of sexual abuse occured on 10/13/25 at 2:30 a.m. The facility was first made aware of the allegation on 10/14/26 at 8:30 a.m. and the initial report to the State Agency was on 10/16/25 at 4:59 p.m. -The occurrence report identified the report was submitted late by the facility. B. Resident #2 (alleged victim)1. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included progressive multiple sclerosis, generalized muscle weakness, major depressive order recurrent, in full remission, post-traumatic stress disorder, generalized anxiety and tobacco use.The 2/4/26 minimum data set (MDS) assessment identified Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out 15. The MDS assessment indicated Resident #2 used a wheelchair for mobility and was independent with most of her activities of daily living (ADLs). According to the MDS assessment, the resident had delusional behavioral symptoms.2. Resident interview and observationsResident #2 was interviewed on (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/17/26 at 1:45 p.m. Resident #2 said one of the residents at the facility kissed her. She said Resident #1 had come into her room, closed her room door and kissed her on the mouth while she was asleep in her bed two or three months ago. She said prior to Resident #2 kissing her on the mouth, he would occasionally kiss her on the forehead. Resident #2 said she was fearful of Resident #1 when he kissed her on the mouth and was angry, but said it was a couple of months ago and she was no longer fearful of him because he had not done anything recently to her. She said staff were aware of her concern and she felt that she could handle the situation if anything happened again.3. Record review-Review of Resident #2's progress notes on 10/13/25 did not document the 10/13/25 allegation between Resident #1 and Resident #2.C. Resident #1 (alleged assailant)1. Resident statusResident #1, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included mild cognitive disorder due to known physiological condition without behavioral disturbance, post-traumatic stress disorder, chronic, major depressive disorder, single episode, unspecified dementia and specified severity without behavioral disturbance psychotic disturbance or mood disturbance, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and tobacco use.The 2/7/26 MDS assessment identified Resident #1 was cognitively intact with a BIMS score of 13 out 15. The MDS assessment indicated Resident #1 did not use a mobility device and was independent with most of his ADLs. The MDS assessment did not indicate he had inattention, disoriented thinking or behaviors directed towards himself or others. According to the MDS assessment, Resident #1 had wandering behaviors. B. Record review-Review of Resident #1's progress notes on 10/13/25 or 10/14/25 did not document the allegation between Resident #1 and Resident #2.III. Incident between Resident #1 and Resident #5Record review and interviews during the survey (see below) identified a 12/22/25 allegation of sexual abuse involving Resident #1 and Resident #5 was not reported to the State Agency.Cross reference F610: failure to thoroughly investigate an allegation of abuse.A. Resident #51. Resident statusResident #5, age greater than 65, was admitted on [DATE] and discharged on 1/12/26. According to the January 2026 computerized physician orders (CPO), diagnoses included heart failure, unspecified mood disorder, anxiety disorder and nicotine dependence. The 12/12/25 MDS assessment identified Resident #5 was cognitively intact with a BIMS score of 13 out 15. The MDS assessment indicated Resident #5 independent with mobility and most of her ADLs. The MDS assessment did not indicate behaviors directed towards herself or others.2. Record reviewThe 12/22/25 behavior note documented Resident #5 said that Resident #1 leaned down to kiss her but she moved her head and the kiss landed on her cheek rather than her lips. According to the note, Resident #1 said the kiss made her feel very uncomfortable and she did not view Resident #5 as a romantic interest. The note identified that Resident #5 felt Resident #1 had become increasingly more invasive over time. The note documented Resident #5 said a few weeks ago (from the time the note was written), Resident #5 was engaging in a phone conversation with a family member when was interrupted by Resident #1 who was outside listening in on the conversation. The note documented Resident #5 felt unsure of what to do about behavior from Resident #1. The note documented Resident #5 was reassured by the nurse that staff would be able to assist her in uncomfortable situations with Resident #1.The 1/3/26 nursing note identified Resident #5 came up to the nurses' station on 1/3/26 at 3:45 a.m. and said that she felt unsafe with Resident #1. According to the note, the resident reported Resident #1 tried to kiss her the other day on the porch in the smoking area and came into her room. The note documented the assistant director of nursing (ADON) was informed of the incident. B. Resident #11. Record reviewThe 12/22/25 behavior note for Resident #1 documented a certified nurse side (CNA) reported seeing Resident #1 kiss a female resident (Resident #5) on the outside smoking porch. According to the note, the registered nurse (RN) attempted to speak to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 regarding the incident. Resident #1 became defensive and stated that he did not know any information about the incident and denied anything happened. According to the note, Resident #1 became angry and refused to continue the conversation with the RN.IV. Staff interviewsThe NHA was interviewed on 2/17/26 at 4:05 p.m. The NHA said Resident #1 had two incidents of potential sexual inappropriateness with two different residents (Resident #2 and Resident #5). The NHA said Resident #2 claimed that she was unwillingly kissed by Resident #1 on 10/13/25 while she was asleep in her bed. The NHA said he reported the incident to the State Agency because the resident's allegation was related to sexual abuse from another resident. The NHA said the second incident was related to Resident #5, who had since been discharged from the facility. He said he was told Resident #1 traded cigarettes with Resident #5 for a kiss. He said the incident was not reported to the State Agency because he was under the understanding that the kiss was mutually agreed upon. The director of nursing (DON) and the ADON were interviewed together on 2/17/26 at 4:25 p.m. The ADON said it was reported to her that Resident #1 kissed Resident #5's cheek when they were outside. She said the kiss made Resident #5 feel uncomfortable. The ADON said Resident #5 alleged Resident #1 would stand outside of her door and listen to her phone conversations. The ADON said she reported the allegations to the interdisciplinary team (IDT) after it was reported to her. The DON said said she did not believe she was at the facility when it was reported that Resident #1 kissed Resident #5. The ADON said after an allegation was reported, the facility would investigate the allegation. She said the facility would investigate anything out of the ordinary. The ADON said a report of a resident not feeling comfortable when kissed by another resident would rise to the level of an investigation. The DON said anything that met the criteria of potential abuse should have been reported to the State Agency. She said the incident involving Resident #5 and Resident #1 would be reportable. The DON said the incident should have been reported and then investigated. The NHA was interviewed again on 2/17/26 at 4:47 p.m. The NHA said when there was a reportable allegation, the facility would generally interview staff and residents to determine if other residents had similar experiences of potential abuse or an awareness of potential abuse. The NHA said he reported Resident #2's 10/13/25 allegation to the State Agency but it was reported late, on 10/16/25. He said he thought allegations of potential abuse needed to be reported within 48 hours. He said he had since learned that allegations should be reported within 24 hours to the State Agency. The DON was interviewed again on 2/17/26 at 5:50 p.m. The DON said she was currently in the process of educating staff on abuse allegations and how to take appropriate actions. VI. Facility follow up A 2/18/26 email sent by the DON identified the facility conducted leadership training on 2/18/26 related to reporting of alleged violations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to timely investigate an allegation of abuse involving three (#2, #1 and #5) of five residents reviewed for abuse out of five sample residents.Specifically, the facility failed to throughly investigate allegations of sexual abuse by Resident #1 towards Resident #2 and Resident #5. Findings include:I. Facility policy and procedureThe Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy, revised September 2022, was provided by the nursing home administrator (NHA) on 2/17/26 at 5:59 p.m. It read in pertinent part, All reports of resident abuse, neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If abuse, neglect, exploitation, or misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and two other officials according to state law. The administrator or other individuals making the allegation immediately reports his or her suspicion to the following person or agencies: The state licensing/certification agencies responsible for surveying/licensings of facility; the local/state ombudsman; the residents' representative; aAdult Protective services; law enforcement officials; and, facility medical director. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions are needed for the protection of residents.According to the policy, the facility should report within two hours of the allegation involving abuse or result in serious bodily injury or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.The abuse policy identified how the facility should investigate allegations. The policy documented in pertinent part, All allegations are thoroughly investigated. The administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating and reporting such allegations. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. The administrator is responsible for keeping the resident and his/her representative informed of the process of the investigation. According to the policy, person conducting the investigation would as a minimum would review the documentation as evidence; review the residents' medical record determine the residents' physical and cognitive status at the time of the incident and since the incident; observe the alleged victim, included in his or her interactions with staff and other residents; interview the persons reporting the incident; interview any witnesses to the incident; interviews the resident or the residents representative; interviews the resident's attending physician as needed determine the residence condition; interview staff members who have had contact with the resident during the period of the alleged incident; interview the resident's roommate, family members, and visitors; review all events leading up to the alleged incident; and document the investigation completely and thoroughly. II. Incident between Resident #1 and Resident #2A. Facility investigation A 10/13/25 sexual abuse investigation was provided by the NHA on 2/17/26 at 4:05 p.m. The investigation provided was an incident reported submitted to the State Agency on 10/16/25. According to the incident report, the incident that prompted the allegation of sexual abuse occured on 10/13/25 at 2:30 a.m. The facility was first made aware of the allegation on 10/14/26 at 8:30 a.m. and the initial report to the State Agency was on 10/16/25 at 4:59 p.m. The occurrence report identified the report was submitted late by the facility. The investigation report identified Resident #2 said she was kissed unwillingly by Resident #1. Resident #1 and Resident #2 were separated and observations of both residents were increased. The investigation documented (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2 said Resident #1 entered her room in the early morning hours on 10/13/25 and kissed her while she slept in her bed. Resident #2 said she woke up to Resident #1 leaning over her and kissing her. Both residents were interviewed. The investigation documented Resident #1 had dementia, was not oriented to time and place, and could not remember the incident. The investigation documented Resident #2 could not describe the details of the incident or the precise time of the event, when she was investigated. -The investigation did not identify when Resident #1 and Resident #2 were interviewed.The investigation indicated the staff were interviewed along with residents who were in the proximity to the Resident #2's room. The investigation indicated there were no witnesses and the residents felt safe and cared for. The investigation documented Resident #1's change in care plan as result of the occurrence was to redirect Resident #1 away from Resident #2 when she requested Resident #1 to push her in her wheelchair to her room. The investigation documented there were no changes to Resident #2's care plan. According to the investigation, staff were asked to redirect Resident #1 and Resident #2 away from each other to prevent a recurrence. The investigation identified the allegation of sexual abuse was unsubstantiated.-Review of the investigation did not identify the events leading up to the allegation. The investigation did not identify where Resident #1 was or what he was doing prior to the alleged time of 2:30 a.m. or when he was last seen by staff. -The investigation did not identify where staff was or what they were doing at the alleged time of the incident. -The investigation identified that staff and residents were interviewed but it did not include who and when the staff and residents were interviewed. The investigation did not include documented interviews by staff and residents. B. Resident #2 (alleged victim)1. Resident statusResident #2, age greater than 65, was admitted on [DATE]. According to the February 2026 computerized physician orders (CPO), diagnoses included progressive multiple sclerosis, generalized muscle weakness, major depressive order recurrent, in full remission, post-traumatic stress disorder, generalized anxiety and tobacco use.The 2/4/26 minimum data set (MDS) assessment identified Resident #2 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out 15. The MDS assessment indicated Resident #2 used a wheelchair for mobility and was independent with most of her activities of daily living (ADLs). According to the MDS assessment, the resident had delusional behavioral symptoms.2. Resident interview and observationsResident #2 was interviewed on 2/17/26 at 1:45 p.m. Resident #2 said one of the residents at the facility kissed her. She said Resident #1 had come into her room, closed her room door and kissed her on the mouth while she was asleep in her bed two or three months ago. She said prior to Resident #2 kissing her on the mouth, he would occasionally kiss her on the forehead. Resident #2 said she was fearful of Resident #1 when he kissed her on the mouth and was angry but said it was a couple of months ago and she was no longer fearful of him because he had not done anything recently to her. She said staff were aware of her concern and she felt that she could handle the situation if anything happens again.Resident #2 said Resident #1 would also go to her window from the outside and look into her room. Resident #2 said she had to yell at the top of her lungs for staff when he would come to her window. She said she wanted to have her privacy and if he did it again she would call the police. She said the staff had talked about getting her a screen over the window that let light in and she could see out but Resident #1 could not see into her room. She said she had not heard anything more about it and she was still waiting for it. She said he had not looked into her window for a couple months but felt it was because it had been cold outside. Resident #2 said Resident #1 could see her window from the smoking area and he would tell her that he noticed her lights were on in her room. She said she kept her window blinds down so he could not look into her room. She said she did not like the blinds down because she liked to look outside, but she did not feel safe (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enough to keep them open. Resident #2 said it was hard to know how to deal with Resident #1. She said he had dementia and would forget that he should not look into her window or go into her room. She said she smoked independently in the smoking area on the back porch and Resident #1 was always there. She said he had not done anything inappropriately to her when they were smoking outside. Resident #2 said she was not the only female resident that he had interest in. She said he would try to come on to/flirt with Resident #5 before she was discharged from the facility (see record review and interviews below). During the 2/17/26 interview with Resident #2, Resident #1 was observed at 2:07 p.m. to leave the back porch of the smokers' area. He crossed over the lawn, towards the window of Resident #2 while she was in her room and entered the facility by use of a side door near Resident #2's room. Resident #1 did not enter Resident #2's room. At 2:25 p.m. Resident #2 self propelled herself in her wheelchair out to the porch of the smokers' area. At 2:29 p.m. Resident #1 opened the outside door to the smokers' area, saw Resident #2 and called her sweetheart as he proceeded out the door.At 2:37 p.m. Resident #1 and Resident #2 entered back into the facility. Resident #1 pushed Resident #2 down two of the hallways and past a nurses' station. When the residents arrived on her hall, Resident #2 told Resident #1 that she could go the rest of the way to her room. Resident #2 propelled herself down her hallway and into her room. Resident #1 turned around and left the area. -The 2/17/26 observation did not identify staff intervened or encouraged Resident #1 not to push Resident #2's wheelchair. The staff was not observed to offer to push Resident #2 in her wheelchair instead of Resident #1.Resident #2 was interviewed again on 2/17/26 at 2:43 p.m. Resident #2 said Resident #1 was talking to her outside when they both were smoking and he was appropriate to her. She said he would forget that he was not supposed to push her wheelchair and he had helped her get to her hallway. She said she made sure he did not take her all the way to her room but it was really convenient for her when he helped her down the other long two halls. 3. Record reviewThe behavior care plan, revised 2/6/26, documented Resident #2 had a history of making allegations about other residents regarding peers standing over her bed, watching her sleep and accused staff of allowing the situation to happen. The care plan indicated Resident #2 had a history of flirtation prior to admitting to the facility and had a history of having caregivers terminated because they made her mad. Interventions included checking in with Resident #2 to ensure she was feeling safe and remind her that staff were available to help (7/30/25), providing a positive attitude when conversing with the resident (5/8/25). According to the care plan, the resident enjoyed when her power of attorney (POA) visited because the POA provided her with new books and personal entertainment items (10/15/25). -Review of the care plan, did not include interventions to help ensure Resident #2's privacy in her room or how to assist her if a resident entered her room unwelcomed or while she was sleeping. The 7/29/25 social service progress note documented Resident #1 gave Resident #2 a letter asking if she liked him in a romantic way. According to the progress note, Resident #2 felt that Resident #1's interest in her was unwanted and she was not interested in him and did not want him to come to her room or her door anymore. The note documented staff would redirect Resident #1 when he attempted to visit Resident #2 and implement 15-minute checks. Review of Resident #2's progress notes on 10/13/25 did not document the 10/13/25 allegation between Resident #1 and Resident #2.C. Resident #1 (alleged assailant)1. Resident statusResident #1, age greater than 65, was admitted on [DATE]. According to the February 2026 CPO, diagnoses included mild cognitive disorder due to known physiological condition without behavioral disturbance, post-traumatic stress disorder, chronic, major depressive disorder, single episode, unspecified dementia and specified severity without behavioral disturbance psychotic disturbance or mood disturbance, anxiety disorder, adjustment disorder with mixed anxiety and depressed mood, and tobacco (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use.The 2/7/26 MDS assessment identified Resident #1 was cognitively intact with a BIMS score of 13 out 15. The MDS assessment indicated Resident #1 did not use a mobility device and was independent with most of his ADLs. The MDS assessment did not indicate he had inattention, disoriented thinking or behaviors directed towards himself or others. According to the MDS assessment, Resident #1 had wandering behaviors. B. Record reviewThe behavior care plan, revised 10/21/25, identified Resident #1 threatened to leave the facility when he was told he was out of money, cigarettes or able to roll cigarettes at the moment and had a history of misinterpreting female kindness for wanting a relationship. According to the care plan, Resident #1 would often push his friend/another resident in a wheelchair. Interventions included directing the staff to validate Resident #1's feelings (6/12/25), gently remind resident that the cigarettes in his case were all the cigarettes he had until a staff member could sit with him to roll more cigarettes and ensure the resident had a full case of cigarettes daily (6/12/25), and reminding him of boundaries of his peers in a gentle tone (7/30/25). According to the care plan, initiated 10/15/25, Resident #1 declined counseling services but would continue to encourage counseling services due to signs and symptoms of depression. The 10/21/25 intervention directed staff to remind Resident #1 that it was not safe for him or any resident to push other residents in their wheelchairs.-However observations on 2/17/26 did not identify that the staff reminded or intervened when Resident #1 pushed Resident #2 in her wheelchair from the smokers' area to her hallway (see observations above). Review of Resident #1's progress notes on 10/13/25 or 10/14/25 did not document the allegation between Resident #1 and Resident #2.III. Incident between Resident #1 and Resident #5Record review and interviews identified an investigation was not available or located and provided when requested regarding a potential sexual abuse allegation on 12/22/25. Cross reference: F609 failure to report to the State Agency.A. Resident #51. Resident statusResident #5, age greater than 65, was admitted on [DATE] and discharged on 1/12/26. According to the January 2026 computerized physician orders (CPO), diagnoses included heart failure, unspecified mood disorder, anxiety disorder and nicotine dependence. The 12/12/25 MDS assessment identified Resident #5 was cognitively intact with a BIMS score of 13 out 15. The MDS assessment indicated Resident #5 independent with mobility and most of her ADLs. The MDS assessment did not indicate behaviors directed towards herself or others.2. Record reviewThe leisure care plan, initiated 1/3/26, identified Resident #5 was independent with her leisure activities. According to the care plan, Resident #5 preferred to watch television in her room and use her phone. Review of Resident #5's comprehensive care plan did not identify she was at risk for abuse or had interventions to prevent unwanted sexual advances from other residents. The care plan did not include interventions to ensure the resident felt safe and comfortable in the facility. The 12/22/25 behavior note documented Resident #5 said that Resident #1 leaned down to kiss her but she moved her head and the kiss landed on her cheek rather than her lips. According to the note, Resident #1 said the kiss made her feel very uncomfortable and she did not view Resident #5 as a romantic interest. The note identified that Resident #5 felt Resident #1 had become increasingly more invasive over time. The note documented Resident #5 said a few weeks ago (from the time the note was written), Resident #5 was engaging in a phone conversation with a family member when she was interrupted by Resident #1 who was outside listening in on the conversation. The note documented Resident #5 felt unsure of what to do about behavior from Resident #1. The note documented Resident #5 was reassured by the nurse that staff would be able to assist her in uncomfortable situations with Resident #1.The 1/3/26 nursing note identified Resident #5 came up to the nurses' station on 1/3/26 at 3:45 a.m. and said that she felt unsafe with Resident #1. According to the note, the resident reported Resident #1 tried to kiss her the other day on the porch in the smoking area and came into (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her room. The note documented the assistant director of nursing (ADON) was informed of the incident. B. Resident #11. Record reviewReview of Resident #1's comprehensive care plan did not identify new interventions were put in place after Resident #1 was observed kissing Resident #5. The 12/22/25 behavior note for Resident #1 documented a certified nurse side (CNA) reported seeing Resident #1 kiss a female resident (Resident #5) on the outside smoking porch. According to the note, the registered nurse (RN) attempted to speak to Resident #1 regarding the incident. Resident #1 became defensive and stated that he did not know any information about the incident and denied anything happened. According to the note, Resident #1 became angry and refused to continue the conversation with the RN.IV. Additional resident interview and observation Resident #4 was interviewed on 2/17/26 at 3:14 a.m. Resident #4 said Resident #1 came into her room all the time. She said he did not knock but would just walk into her room and ask her for soda pop and cigarettes. She said the stop sign banner should have been across her doorway to help prevent Resident #1 from entering her room but the staff never put it back up. Observation outside of Resident #4's doorway revealed there was a stop sign banner attached to the wall by velcro on the right side of the resident's door. The banner was bunched up on top of the hand railing and not across the doorway of the resident's room to deter other residents from coming into her room. Resident #4 said Resident #1 had not done anything inappropriate to her, but she was angry that Resident #4 would come into her room without her permission. V. Staff interviewsCNA #1 was interviewed on 2/22/26 at 2:27 p.m. CNA #1 said Resident #1 could get a little too familiar with other residents. She said he would enter female residents' rooms and they would get upset and she had heard he kissed other female residents. RN #1 was interviewed on 2/17/26 at 3:25 p.m. RN #1 said Resident #1 could get too friendly with other residents and get in their personal space. She said Resident #1 spent a lot of time around Resident #2 and would go near her room. She said staff would redirect him away from Resident #2. RN #1 said the last time she was aware that Resident #2 was not comfortable about Resident #1 being around her was a couple of months ago. She said she saw the two residents outside talking together on 2/16/26 but there did not seem to be any concerns.RN #1 said Resident #1 had an incident with another female resident. RN #1 said Resident #1 kissed Resident #5 on 12/22/25. She said both residents smoked outside and Resident #1 would talk to Resident #5 and joke with her. She said on 12/22/25 Resident #1 and Resident #5 were talking and he leaned over her to kiss her on the mouth and she quickly turned and he kissed her cheek. RN #1 said after that incident, the staff tried to redirect him away from her. RN #1 said she reported the incident to management.CNA #2 was interviewed on 2/17/26 at 2:50 p.m. CNA #2 said was not aware of or been told about any behaviors or anything to watch for with Resident #1 but she would try to redirect a resident's behavior if she saw a concern. She said she did not know of any behavior specific interventions around other residents or any specific residents. The NHA was interviewed on 2/17/26 at 4:05 p.m. The NHA said Resident #1 had two incidents of potential sexual inappropriateness with two different residents (Resident #2 and Resident #5). The NHA said Resident #2 claimed that she was unwillingly kissed by Resident #1 on 10/13/25 while she was asleep in her bed. The NHA said he reported the incident to the State Agency because the resident's allegation was related to sexual abuse from another resident. The NHA said he felt the allegation needed to be investigated to determine if the allegation was valid. He said there was not enough evidence to support the allegation and it was unsubstantiated. The NHA said there were no witnesses that could confirm Resident #2's allegation and Resident #1 did not remember the incident and denied the allegation. The NHA said the second incident was related to Resident #5, who had since been discharged from the facility. He said he was told Resident #1 traded cigarettes with Resident #5 for a kiss. The NHA said the incident was investigated and was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065307	A. Building B. Wing	02/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mantey Heights Rehabilitation & Care Center	2825 Patterson Rd Grand Junction, CO 81506

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	soft filed. He said a soft file was when there was an incident that did not rise to the occasion to report it to the State Agency but was investigated. The director of nursing (DON) and the ADON were interviewed together on 2/17/26 at 4:25 p.m. The ADON said it was reported to her that Resident #1 kissed Resident #5's cheek when they were outside. She said the kiss made Resident #5 feel uncomfortable. The ADON said Resident #5 alleged Resident #1 would stand outside of her door and listen to her phone conversations. The ADON said she reported the allegations to the interdisciplinary team (IDT) after it was reported to her. The DON said said she did not believe she was at the facility when it was reported that Resident #1 kissed Resident #5. The DON said if she was present at the facility at the time of the allegation and was made aware of it, the first measures she would have taken would have been to ensure Resident #5's safety. The DON said when there was an allegation of potential sexual inappropriateness she would usually implement 15-minute checks as a standard procedure and update both residents' care plans. The DON reviewed Resident #5's care plan and said there were no care plan interventions put in place after it was reported that she was kissed by Resident #1 and she felt uncomfortable. The ADON said after an allegation was reported, the facility would investigate the allegation. She said the facility would investigate anything out of the ordinary. The ADON said a report of a resident not feeling comfortable when kissed by another resident would rise to the level of an investigation. The DON said Resident #1 had had other incidents in the past with other female residents. She said in the Fall of 2025, Resident #2 reported a similar allegation about Resident #1. The DON said Resident #1's care plan identified that Resident #1's goal was to understand boundaries with peers and provide him reminders but there were no new care plan interventions created after Resident #2 and Resident#5's allegations to ensure resident and staff safety. She said there should have been new interventions put in place and she would update his care plan. The NHA was interviewed again on 2/17/26 at 4:47 p.m. The NHA said when there was a reportable allegation, the facility would generally interview staff and residents to determine if other residents had similar experiences of potential abuse or an awareness of potential abuse. He said the facility would ask the residents basic abuse questions. The NHA said the facility would normally document the interviews as part of the investigation. He said the investigation would help them determine if the residents felt safe and identify if there were other incidents that were not reported to administration. He said the facility wanted to make sure residents in the facility felt cared for. The NHA said a thorough investigation would help the facility get to the bottom of the allegation and help uncover any potential problems. The NHA said the facility did not have documented evidence to show that other staff and residents were interviewed or more to their investigation other than what was reported to the State Agency. He said he did not know who was interviewed after Resident #2's 10/13/25 allegation. The NHA said he reported Resident #2's 10/13/25 allegation to the State Agency but it was reported late, on 10/16/25. He said he thought allegations of potential abuse needed to be reported within 48 hours. He said he had since learned that allegations should be reported within 24 hours to the State Agency. The NHA said he could not find an investigation related to Resident #1 kissing Resident #5 on 12/22/25. He said he did not feel at the time it was reportable and needed an investigation. He said if Resident #5 said she was uncomfortable about the kiss then it should have been reported and investigated and potential sexual harassment. The NHA said the 1/3/26 progress note that documented she was kissed the other day should have been looked into more to determine if Resident #5 was referring to the 12/22/25 incident or if the 1/3/26 allegation referencing another incident was when she was kissed by Resident #1. The NHA said with both allegations he would want to have documentation to show the incidents were reported and thoroughly investigated. The investigation process would assist in creating (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interventions to help prevent potential occurrences. He said to lower the risk, there should have been care planned interventions. The 2/17/26 observations of Resident #1 pushing Resident #2 in her wheelchair were reviewed with the NHA. The NHA said staff should have known of the intervention to not have Resident #1 push Resident #2 in her wheelchair and help redirect the resident. He said the staff needed more training to make sure they followed the care plan interventions in place. The DON was interviewed again on 2/17/26 at 5:50 p.m. The DON said she was currently in the process of educating staff on abuse allegations and how to take appropriate actions. VI. Facility follow up A 2/18/26 email sent by the DON identified actions taken in response to the above concerns. The facility created an internal plan for correction on dementia care; conducted leadership training on reporting of alleged violations; updated Resident #1's care plan, and were going to review Resident #1's preferences with him. The email indicated the facility would continue to focus on care planning efforts, which included triggers and dementia appropriate interventions.